HEALTH ASSESSMENT

Name | Date

Address | City | ST | Zip | Phone

Email | Date of Birth

Preferred Method Of Contact: ☐ Text ☐ Call ☐ Email

AWAKEN

How did you hear about our program?

Describe where you are in your health now. *Weight, sleep, stress, energy, etc)*

Describe where you would like to be in your health.

Please describe WHY you are interested in getting healthy.
(What is your main Motivation…Relationships, activities, how you will feel, etc)

When was the last time you remember feeling your best in your health or being at your ideal weight or size*(if that's part of your goal)***?**

Medical

**We recommend that clients contact their healthcare provider before starting and throughout their weight loss journey.*

Are you Pregnant ? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No *If yes, how old is your baby?*

Do you have the following:

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ High Blood Pressure
- ☐ Gout

Are you taking any medications for:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Lithium[1]
- ☐ Thyroid[2]
- ☐ Coumadin *(Warfarin)* [3]
- ☐ High Cholesterol

Are there any food or other allergies that I should be aware of:

Are you taking other medications or do you have other medical conditions that could influence which program we choose: →

[1]Lithium: The healthcare provider may wish to adjust frequency of lab work for the client and monitor

[2]Thyroid Medications: The healthcare provider may wish to monitor thyroid hormone levels while the Client is on the Program and adjust medication

[3]Coumadin (Warfarin): The healthcare provider may wish to review food choices, conduct lab work and/or adjust medication

DAILY ROUTINE & HABITS

Research shows that there are 7 significant factors that contribute to overall physical health.

SLEEP

How many hours of sleep do you typically get?

What time do you typically go to bed?

Wake up? | Quality of Sleep?

Do you wake up feeling rested?

HYDRATION

How much water do you drink each day?

How much of other beverages?

Coffee | Soda | Tea | Alcohol

MOTION *(On a scale of 1-10)*

How would you rate your energy level?

What physical activities do you participate in?

How many times a week do you exercise?

Are there things you can't do that you would like to be able to?

STRESS *(On a scale of 1-10)*

How would you rate your stress level?

What do you do for work?

How much do you enjoy what you do?

Are there other stressors in your life?

EATING HABITS

How many meals per day do you eat?

When do you eat your first meal?

When do you eat last meal?

Do you snack between meals?

What kind of snacks?

How many times a week do you eat out?

Where?

WEIGHT

Current Weight | Goal Weight | Height

Have you tried to lose weight before?

What has been most difficult about losing/maintaining weight in the past?

SURROUNDINGS *(On a scale of 1-10)*

How healthy would you rate your surroundings?

(Do you have healthy & active friends, supportive family, keep junk food in the house, etc.)

Is there anyone in your life who would like to get healthy with you?